UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK
==========x
MARIANNE MURPHY and WILLIAM MURPHY

Plaintiff, (s)

Docket #: 07-CIV-9415

-against- **Buchwald, J.**

CONTINENTAL AIRLINES, INC.

Defendant.
==========x

PLAINTIFF'S MARIANNE MURPHY and WILLIAM MURPHY RESPOSNE TO AUTOMATIC DISCLOSURE PRIOR TO DISCOVERY

Please Take Notice that Plaintiff Marianne Murphy and William Murphy by its' attorneys Shaked & Posner hereby requests, as and for its Response to Automatic Disclosure Prior to Discovery in accordance with FRCP Rule 26 (a) (1) of the Federal Rules of Civil Procedure, states:

1. **AUTOMATIC DISCLOSURE 1**: Disclose the identity of all persons with pertinent information respecting claims, defenses and damages.

Response 1: At present time, plaintiff is unaware of any witnesses to this occurrence other than plaintiff's Marianne Murphy and William Murphy.

2. AUTOMATIC DISCLOSURE 2: Disclose a general description of all documents in the custody and control of the parties bearing significantly on the claims and defenses:

Response 2: At this time, plaintiff is aware of the following documents; Continental Airlines Customer Report (copy) is enclosed.

3. **AUTOMATIC DISCLOSURE 3**: Provide authorizations to obtain medical, hospital, no-fault and worker's compensation records

Response 3: Enclosed are authorizations for the following providers of care: Foot

and Ankle Orthopaedic Surgery, Hospital for Special Surgery, East River Medical Anesthesiology and CVS Pharmacies

4. **AUTOMATIC DISCLOSURE 4**: Disclosed the documents relied on by the parties in preparing the pleading or documents that are expected to be used to support allegations:

Response: See response to items 2 and 3 above.

Dated: New York, New York,
November 26, 2007

Yours, etc.

*/s/Michael Posner*_____
Michael Posner(mp3468)
Shaked & Posner
255 West 36th Street – 8th floor
New York, New York 10018
(212) 494-0035

To: Mckeegan & Shearer, P.C.
192 Lexington Avenue
New York, New York 10016
(212) 661-4

Authorization for Use and Disclosure of Health Information

Patient name Mariane Murphy Date of Birth 12-26-55

Previous name _____ ID# 122798

By signing this form, I hereby authorize Hospital For Special Surgery 535 E. 70th St NY, NY 10021 to disclose the health information described below to McKeegan and Shearer, P.C. 192 Lexington Ave NY, NY 10016

(Name and address of Person or Organization)

(Check all that apply):

- ☐ All health information
- ☐ Health information relating to the following treatment or condition _____
- ☒ Health information for the date(s) 9/11/06 On 10/22/07
- ☐ Other specific description _____

Reason for This Authorization

- ☐ At my request
- ☒ Other (specify) Lawsuit
- ☐ _____ has requested this authorization for marketing purposes and (will/will not) receive compensation from a third party.

This authorization expires upon 11-16-08

(date or description of event)

I understand that I may refuse to sign this authorization. Treatment, payment, enrollment in a health plan or eligibility for benefits will not be conditioned on signing an authorization if to do so would be prohibited by federal or state law. I understand an authorization may be required to participate in research or where health care services are provided solely for the purpose of creating health information for a third party, and that if I refuse to sign an authorization those services may be denied.

I may revoke this authorization in writing. If I do, it will not affect any previous actions already taken in reliance upon my authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance. I may revoke this authorization by writing a letter and mailing it by certified mail, return receipt requested, to the Privacy Officer at the health care provider listed above.

Once health information is disclosed pursuant to this authorization, it may be re-disclosed and may no longer be protected by privacy laws.

K Mariane J. Murphy — Patient/Legally Authorized Representative

11-16-07 — Date

Mariane J. Murphy — Printed Name

Self — Relationship to Patient

NOTE: This document must be made part of the patient's medical record. A copy of this document must be given to the patient or legally authorized representative.

Authorization for Use and Disclosure of Health Information

Patient name Mariane Murphy Date of Birth 12-26-55

Previous name _____ ID# _____

By signing this form, I hereby authorize East River Medical Anesthesiology - NY, NY GPO Box 27578 NY, NY 10087 to disclose the health information described below to McKeegan and Shearer, P.C. 192 Lexington Ave NY, NY 10016

(Name and address of Person or Organization)

(Check all that apply):

- ☐ All health information
- ☑ Health information relating to the following treatment or condition Left Foot Injury
- ☐ Health information for the date(s) 4-1-06 Surgery Forever
- ☐ Other specific description _____

Reason for This Authorization

- ☐ At my request
- ☑ Other (specify) Lawsuit
- ☐ _____ has requested this authorization for marketing purposes and (will/will not) receive compensation from a third party.

This authorization expires upon 11-16-08

(date or description of event)

I understand that I may refuse to sign this authorization. Treatment, payment, enrollment in a health plan or eligibility for benefits will not be conditioned on signing an authorization if to do so would be prohibited by federal or state law. I understand an authorization may be required to participate in research or where health care services are provided solely for the purpose of creating health information for a third party, and that if I refuse to sign an authorization those services may be denied.

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Once health information is disclosed pursuant to this authorization, it may be re-disclosed and may no longer be protected by privacy laws.

X Mariane J. Murphy
Patient/Legally Authorized Representative

11-16-07
Date

Mariane J. Murphy
Printed Name

Self
Relationship to Patient

NOTE: This document must be made part of the patient's medical record. A copy of this document must be given to the patient or legally authorized representative.

Authorization for Use and Disclosure of Health Information

Patient name Marianne Murphy Date of Birth 12-26-55

Previous name ______ ID# ______

By signing this form, I hereby authorize Foot & Ankle Orthopaedic Surgery - 523 E. 72nd St. NY, NY 1002 to disclose the health information described below to McKeegan and Shearer, P.C. 192 Lexington Ave NY, NY 10016

(Name and address of Person or Organization)

(Check all that apply):

- ☐ All health information
- ☑ Health information relating to the following treatment or condition Left Foot Injury
- ☑ Health information for the date(s) 4-1-06 Forward
- ☐ Other specific description ______

Reason for This Authorization

- ☐ At my request
- ☑ Other (specify) Lawsuit
- ☐ ______ has requested this authorization for marketing purposes and (will/will not) receive compensation from a third party.

This authorization expires upon 11-16-08
(date or description of event)

I understand that I may refuse to sign this authorization. Treatment, payment, enrollment in a health plan or eligibility for benefits will not be conditioned on signing an authorization if to do so would be prohibited by federal or state law. I understand an authorization may be required to participate in research or where health care services are provided solely for the purpose of creating health information for a third party, and that if I refuse to sign an authorization those services may be denied.

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Once health information is disclosed pursuant to this authorization, it may be re-disclosed and may no longer be protected by privacy laws.

X [signature] 11-16-07
Patient/Legally Authorized Representative Date

Marianne A. Murphy Self
Printed Name Relationship to Patient

NOTE: This document must be made part of the patient's medical record. A copy of this document must be given to the patient or legally authorized representative.

Authorization for Use and Disclosure of Health Information

Patient name Marianne Murphy Date of Birth 12-26-55

Previous name ______ ID# ______

By signing this form, I hereby authorize CVS Pharmacy - 1622 3rd Avenue NY, NY 10028
to disclose the health information described below to McKeegan and Shearer, P.C.
192 Lexington Ave NY, NY 10016
(Name and address of Person or Organization)

(Check all that apply):

☐ All health information
Health information relating to the following treatment or condition ______

☑ Health information for the date(s) 4-1-06 Forward
☑ Other specific description Pharmaceutical Record

Reason for This Authorization

☐ At my request
☑ Other (specify) Lawsuit
☐ ______ has requested this authorization for marketing purposes and (will/will not) receive compensation from a third party.

This authorization expires upon 11-16-08
(date or description of event)

I understand that I may refuse to sign this authorization. Treatment, payment, enrollment in a health plan or eligibility for benefits will not be conditioned on signing an authorization if to do so would be prohibited by federal or state law. I understand an authorization may be required to participate in research or where health care services are provided solely for the purpose of creating health information for a third party, and that if I refuse to sign an authorization those services may be denied.

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Once health information is disclosed pursuant to this authorization, it may be re-disclosed and may no longer be protected by privacy laws.

Marianne A. Murphy | 11-16-07
Patient/Legally Authorized Representative | Date

Marianne A. Murphy | Self
Printed Name | Relationship to Patient

NOTE: This document must be made part of the patient's medical record. A copy of this document must be given to the patient or legally authorized representative.

Continental Airlines

CUSTOMER REPORT

FORM TO BE COMPLETED BY **CUSTOMER** ONLY
THEY MAY COMPLETE IT ON THE SPOT, OR TAKE IT WITH THEM
AND MAIL IT TO THE ADDRESS AT THE BOTTOM OF THE FORM

NAME OF CUSTOMER OR INJURED PARTY	FIRST	INITIAL	LAST			
HOME ADDRESS	STREET NO.	CITY	STATE	ZIP	TELEPHONE #	
SOCIAL SECURITY NO.	SEX	DOB	OFFICE TELEPHONE #			

DATE AND TIME OF INCIDENT A.M. P.M.	DESCRIBE THE EXACT LOCATION OF INCIDENT
FLIGHT # FROM: TO:	

WAS EMERGENCY TREATMENT OFFERED? Y/N
IF YES, WHO PROVIDED TREATMENT?

WAS IT ACCEPTED? Y/N
IF NO, WHY NOT?

DESCRIBE THE INCIDENT IN DETAIL:

DESCRIBE INJURY:

WITNESSES (PRINT): NAME ADDRESS TELEPHONE #

SIGNATURE: _____

DATE: _____

INFLT 24 (10/04)
00-0703-3-1299

MAIL TOP (WHITE) COPY TO:

CONTINENTAL AIRLINES
RISK MANAGEMENT DEPARTMENT - HQSRK
P.O. BOX 4607
HOUSTON, TX 77210-4607

CUSTOMER TO KEEP YELLOW COPY